- ❑ Initiate Waiver services
- ❑ Service Modification
  - ☐ Add a service
  - ☐ Increasing hours of service
  - ☐ Decreasing hours of service
- ❑ Provider Modification (requires 2 ISARs)
- ❑ End a service

MR Waiver Therapeutic Consultation Individual Service Authorization Request

CSB _____

CSB provider #

_____

Provider Name _____ Provider Number _____

Name: _____ Start: _____ End: _____

Last, First MI Date Date

Medicaid Number: _____

Only Behavioral Consultation may be provided in the absence of other MR Waiver services.

CHECK SERVICE TO BE PROVIDED	HOURS NEEDED	OMR USE ONLY
97139 Therapeutic Consultation ☐ Behavioral ☐ Psychological ☐ Speech ☐ Occupational ☐ Physical ☐ Recreational ☐ Rehabilitation Engineering		

Reason for this request:

Check the allowable activities that are included in the ISP. Indicate the total number of hours for each section below:

(May not be direct therapy, evaluations, or services available through the Medicaid State Plan.)	**Hours needed in each area**
Assessment/evaluation: ☐ interviewing to identify issues to be addressed/desired outcomes ☐ observing in daily activities and natural environments ☐ assessing need for assistive device or modification/adjustment in environment or services ☐ developing data collection mechanisms and collecting baseline data ☐ observing & assessing current interventions, support strategies, or assistive devices ☐ reviewing documentation & evaluating efficacy of assistive device or interventions suggested	
Training, consultation & technical assistance to program staff/family: ☐ training in better supporting the individual through enhanced observations of environment/routines/interactions ☐ reviewing documentation & evaluating staff/family activities ☐ demonstrating/training in specialized therapeutic interventions or use of assistive devices	
Assistance in design & integration of individual objectives as part of the overall individual program planning process: ☐ designing & developing a written Support Plan ☐ making recommendations related to specific devices/technology or adapting other training programs/activities	

Comments: _____

Name of Provider Agency Representative (print) Signature Date

I agree that the above plan of services is appropriate to the identified needs of this individual. This service plan has been approved by the individual and included in the CSP maintained in the Case Manager's record.

CSB Rep/ Case Manager (print)	Signature	Phone No.	Fax No.	Date